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A Systematic Utilization Review of a Community Mental Health Program for Latinos

Abstract

This study reviewed the utilization of services of the MIOS Program, a mental health program offering therapy, case management, and psychiatric services to uninsured, Spanish-speaking individuals in the Portland, Oregon metropolitan area. The study was conducted retroactively, using data from the MIOS Program as it was operated as a sub-program of Cascadia Behavioral Healthcare. It was based on a study conducted by Pérez and Fortuna (2005), which described the mental health care needs of undocumented Latino immigrants to the USA. Demographic information as well as diagnoses, time in treatment, immigration information, and utilization of various aspects of the MIOS Program was collected for 100 adult clients enrolled in the MIOS Program during its time with Cascadia Behavioral Healthcare. Description of these variables is provided and recommendations for further mental health services for this population are given. The results of this study reaffirm the importance of providing culturally sensitive and comprehensive treatment to individuals in this population and demonstrate a need for more of these services in the Portland area.

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A SYSTEMATIC UTILIZATION REVIEW OF A COMMUNITY MENTAL HEALTH
PROGRAM FOR LATINOS

A DISSERTATION
SUBMITTED TO THE FACULTY
OF
SCHOOL OF PROFESSIONAL PSYCHOLOGY

PACIFIC UNIVERSITY
HILLSBORO, OREGON

BY
ABIGAIL R. HITCHEN
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TABLE OF CONTENTS

	Page
ABSTRACT	iii
ACKNOWLEDGMENTS	iv
LIST OF TABLES	v
LIST OF FIGURES	vi
INTRODUCTION AND REVIEW OF LITERATURE	1
Demographics and Rationale for Review	1
Overview of Latino Mental Health Issues	4
Barriers to Mental Health Care/Reasons for Underutilization.....	9
Review on Culturally Competent (CC) Treatment for Latinos	12
Review on Evaluating Mental Health Services for Latinos.....	15
Description of Study	16
METHODS	20
RESULTS	26
DISCUSSION	40
REFERENCES	52

ABSTRACT

This study reviewed the utilization of services of the MIOS Program, a mental health program offering therapy, case management, and psychiatric services to uninsured, Spanish-speaking individuals in the Portland, Oregon metropolitan area. The study was conducted retroactively, using data from the MIOS Program as it was operated as a sub-program of Cascadia Behavioral Healthcare. It was based on a study conducted by Pérez and Fortuna (2005), which described the mental health care needs of undocumented Latino immigrants to the USA. Demographic information as well as diagnoses, time in treatment, immigration information, and utilization of various aspects of the MIOS Program was collected for 100 adult clients enrolled in the MIOS Program during its time with Cascadia Behavioral Healthcare. Description of these variables is provided and recommendations for further mental health services for this population are given. The results of this study reaffirm the importance of providing culturally sensitive and comprehensive treatment to individuals in this population and demonstrate a need for more of these services in the Portland area.

Key terms: Latino mental health, culturally sensitive treatment, community mental health, Spanish-speaking

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LIST OF TABLES

TABLE 1. Axis I First Diagnosis Breakdown	33
TABLE 2. Gender and Diagnosis	35
TABLE 3. Axis I Second Diagnoses or Ruleouts	36

LIST OF FIGURES

FIGURE 1. Number of Sessions Attended	27
FIGURE 2. Suicidal Ideation in Participants	29
FIGURE 3. Number of Years Living in the USA.....	31
FIGURE 4. Age of Migration to USA	32
FIGURE 5. Breakdown of Axis I Diagnoses.....	33
FIGURE 6. Breakdown of Second Diagnoses and Ruleouts.....	35
FIGURE 7. Type of Trauma Experience	37
FIGURE 8. Breakdown of Psychosocial Factors.....	38

INTRODUCTION

Demographics and Rationale for Review

The population of the United States of America (USA) is rapidly becoming more and more diverse, with minority groups increasing in number each year. Because of this dramatic change in the make up of the USA population, it can be expected that there will be a higher demand for psychological services available to individuals of different ethnicities and cultural backgrounds. Furthermore, these individuals often speak a language other than English as their primary language. Of these expanding minority groups, the Spanish-speaking, Latino community in the USA is the most quickly growing (Marotta & Garcia, 2003). These authors note that there are currently 41.3 million Hispanic individuals living in the USA, making one out of every seven people of Hispanic origin. It has been estimated that by the year 2050, those of Hispanic origin will constitute 25% of the USA population. Those of Hispanic origin in the USA belong to many different cultural groups, including those of Puerto Rican, Cuban, Dominican, Central American, and Mexican descent. Each of these groups speaks varying dialects of Spanish and presumably requires different cultural approaches to mental health care. For many of these individuals, Spanish is second to a native language, creating difficulties in communication with mental health care workers. Furthermore, many individuals of Hispanic origin living in the USA are undocumented immigrants or migrants to the country, leading population estimates to be significantly underestimated. The Mexican American population is the largest of the Hispanic groups in the USA, numbering approximately 20 million, and settling primarily on the West Coast, East Coast, and Southwestern part of the country (Añez, Paris, Bedregal, Davidson, & Grilo, 2005).

Alegría et al. (2007) found that Mexicans tend to be younger than other Latino immigrant groups, to have less education, less income, and have a higher tendency to be married.

There are several reasons for migration from México to the USA, in particular the northern states of Oregon and Washington. As California becomes more saturated with immigrants from México, immigrants move north to find more jobs and less threat of being found and deported by United States Immigration and Naturalization Services. They come to the USA to find work, as much of the time in their country work does not exist, and come out of desperation to provide for their families. Social networks among immigrants also provide for reasons which many from a particular area in México might end up in a particular area of the USA. For example, much of the population of immigrants in Oregon is from the state of Michoacán, México. Social networks have brought family members and friends of those already in Oregon to be together and find work. In comparison to the migration of Mexicans to California, the move to the Northwest corner of the USA is fairly recent, dating back to approximately 1988. Many of the immigrants to the USA come with the hopes of creating a capital and being able to return to their home country. As they continue to work they often realize the difficulty of gaining capital in this country and are forced to stay, marrying and having families in the USA. These individuals rely on social networking as well as community resources dedicated to helping Spanish-speaking individuals and creating a community for them (Reséndiz Arroyo, 2008). Because of this rising number of individuals arriving to the USA, it is imperative that researchers continue to investigate that specific needs of these immigrants with regards to mental health services (Alegría et al., 2007).

The growing number of Hispanics in the USA also implies a need for mental health services offered in the individual's native language, or, if this is not possible, the individual's second language. The number of individuals speaking Spanish at home continues to rise nationally, recently climbing from 7.5% to 10.7% (Marotta & Garcia, 2003). Castaño, Biever, González, & Anderson (2007) reported that there are 26.7 million Hispanics in the USA who speak Spanish at home, with 12.5 million of these individuals speaking English "less than very well". As those who speak Spanish as a first language have been found to be underserved in the mental health field (Rogler, 1996), it is important that there exist more services in these individuals' native language. This dissertation will review the current needs of the Latino population living in the USA, including patterns of mental health care utilization and common mental health issues, and appropriate treatment for use with this population.

At the time of this writing, individuals of Latino origin made up 10.5% of all persons living in Multnomah County, Oregon. However, this number is likely higher than 10.5%, due to the fact that the US Census Bureau uses the term "Hispanic" to collect data, and according to the bureau, "Hispanics can be of any race, so also are included in applicable race categories" (US Census Bureau, 2007). This number equates to approximately 49,000 Latinos living in Multnomah County (US Census Bureau, 2007). Presumably those who are not documented are likely not largely represented in census data, so this number is probably an underestimation of the Spanish-speaking Latino individuals residing in the area. A descriptive clinical chart review was conducted using mental health charts of individuals seen in the MIOS program in Portland, Oregon, and recommendations for future mental health services in this area will be given.

Overview of Latino Mental Health Issues

There are several reasons for which individuals of this Latino, Spanish-speaking population might seek mental health services. Latinos in the USA are disadvantaged in several ways when compared to the non-Latino population, which can contribute to higher rates of mental health issues as well as different issues than those frequently seen in the non-Latino population. One of the most common reasons included for seeking mental health services is trauma related to the migration/immigration experience (Añez, Paris, Bedregal, Davidson, & Grilo, 2005). Acculturative stress can lead to many mental health issues as well, as the individual copes with trying to communicate in a new language, distance from close friends and family members, and adjusting to a very different culture. Another aspect of acculturative stress that likely affects utilization of mental health services is that of discrimination. Both racial and ethnic discrimination occur frequently toward this population (Acevedo-Polakovich et al., 2007). It has been found that acculturative stress is related to a high rate of utilization of mental health services in the USA (Mezzich, Ruiz, & Muñoz, 1999), an indication that there will likely be a higher need for services as more Latino individuals come to this country. Along with this finding, Alegría et al. (2007) have conducted several studies which confirm that recent immigration to the USA can be a protective factor against mental health issues, particularly in the Mexican immigrant population, which they have termed the Immigration Paradox. Specifically, the more recently an individual arrived, the more he or she appears to be resistant to mental health problems. Consequently, those who seek services as a result of acculturative stress are likely to have been in the country for a longer period of time. Pérez et al. (2008) reported that discriminatory experiences are

related to how people may feel with regard to pursuing health care as well as what they expect to receive from health care in the USA. In keeping with this trend of the Immigrant Paradox found by Alegría et al., Pérez et al. found that Mexican immigrants who had been in the USA for a longer period of time and were considered more acculturated reported higher rates of discrimination than those who were considered less acculturated. In this way, being a recent immigrant to the USA once again could be considered a protective factor, in that new immigrants rarely understand English enough to perceive discriminatory comments. However, they will not, clearly, be protected from physical discriminatory attacks (Pérez et al., 2008).

Due to the fact that, as mentioned above, many of the Latino individuals in this country are undocumented immigrants or migrants to the USA, they face additional, unique stressors (Pérez & Fortuna, 2005). These Latinos experience a high rate of stressors, including economic struggles due to difficulty finding work in the USA, trouble navigating a foreign language, educational barriers, discrimination, and social adjustment struggles (Rosado and Elias, 1993). It has been found that Latino groups have lower incomes than European Americans, Asian Americans, and African Americans (Acevedo-Polakovich et al, 2007). Due to these economic struggles, immigrant and migrant Latinos in the USA often face poor living conditions as well (Añez, Paris, Bedregal, Davidson, & Grilo, 2005).

The political atmosphere of the USA is also cause for difficulty in adjustment and psychological functioning among Latinos. This group is currently widely unable to qualify for health care and many types of governmental aid (Pérez & Fortuna, 2005). This additional stressor may contribute to increased anxiety and need for mental health care.

Since these individuals often do not have health care coverage but need mental health services, programs funded through the state, county, or city are important.

Regarding specific mental health issues and diagnoses prevalent in this Latino population, this group has been found to have high rates of substance and alcohol abuse and dependence, as well as higher rates of Panic Disorder and Dysthymia among Latina women. Individuals of this group have been found to have similar rates of Depression when compared to non-Latino groups (Pérez & Fortuna, 2005). Latinos are given poorer prognoses and more severe diagnoses than middle-class Anglo-Americans and are more likely to be treated using medication than psychotherapy (Rosado & Elias, 1993). Also, clients who are evaluated in Spanish have been found to be labeled with more severe symptomatology than when they are interviewed in English (Acevedo-Polakovich et al, 2007).

Latinos often face similar mental health issues to other groups in the USA, but clearly also face a unique set of issues that are important to take into account when working with this population. Acculturation, intergenerational gaps in what is a family-centered culture, and stressors associated with coming to the USA are among the most unique and important reasons for these individuals seeking mental health services in this country.

Alegria et al. (2007) conducted a large research study named The National Latino and Asian American Study, in order to find out more about the needs of Latinos and Asians in the USA, after finding that little information exists about the mental health needs of these individuals and to determine possible unique factors of these ethnic groups that may aid in understanding how mental health symptoms are expressed similarly or

differently in these groups. The authors posited that “investigating the role of social position, environmental context and psychosocial factors may help identify the mechanisms that link acculturation to psychiatric illness and mental health service use” (p. 212). As has been found in several research studies, the cultural background of an individual strongly influences how symptoms present as well as how they are perceived by American mental health providers. This can influence greatly the treatment an individual is given and how well he or she is understood in the context of mental health treatment (Favazza & Oman, 1984; Kleinman, 1988; Westermeyer and Janca, 1997; Karno & Jenkins, 1993; Ribeiro, 1994).

Although the barriers of immigration and additional stressors that come along with it are many, the Alegría et al. study found a trend in Latino mental health called the Immigrant Paradox (“despite disadvantages associated with immigration and acculturative processes, foreign nativity combined with lower levels of acculturation is protective against psychiatric disorders”, p. 217), particularly in Mexican Americans. In 2008, Alegría et al. compounded on this finding, reporting that Latinos born in the USA displayed a greater amount of risk for several mental health disorders than those who had immigrated. They concluded that the culture of the USA and lifestyles typically prevalent in this country tend to lead to more prevalence of mental health problems. Thus, being a Mexican immigrant to the USA can also be a protective factor for these individuals. However, there are several hypotheses as to why this finding may have come about. First, México is a country that suffers from great poverty as well as socio-economic inequality that frequently lends to individuals fleeing to pursue equality and opportunity. Individuals who have suffered inequality and challenges throughout life may not have a higher

resilience to difficulties faced in the USA. Secondly, the cultural factors of depending on family members for support as well as a fatalistic attitude toward life may protect these individuals from developing psychiatric problems. Thirdly, as immigrants tend to not speak English and often do not involve themselves in mainstream American activities, they may interact less with Americans and be less likely to experience discrimination, preventing them from experiencing psychiatric symptoms related to this (Alegría et al., 2008). Fourthly, Alegría et al. (2007) posit that there may be a lack of ability to recognize mental health problems as what they are. Based upon their finding that the foreign-born Latino immigrants in the study tended to not use mental health services but did not demonstrate a disparity in utilization of physician and medical services, Alegría et al. concluded that this lack of recognition paired with a fear and sensitivity to the stigma and opinions of others may prevent seeking of mental health services. Finally, immigrants are often not legally present in the country, which may lead them to not pursue mental health services for reasons of lack of insurance, fear of being reported to Immigration and Naturalization Services, and a lack of being able to navigate and understand the system.

Alegría et al. (2007), consistent with the Immigration Paradox trend, found that Latino immigrants regardless of immigration age displayed significantly lower substance use disorder rates than Latinos born in the USA. The protective factors listed above likely contribute to these lower rates in the immigrant population. The authors posit that findings that Latino immigrants have higher rates of mental health disorder in general may be related to the fact that substance use disorders are often linked to other mental health problems such as depression and anxiety. The authors also found that Latinos who spoke English reported higher rates of mental health disorders than those who were not

fluent or proficient in English. The inability to understand and perceive symptoms or the mental health system in general may contribute to these findings. The authors conclude that above all, the proficiency in English of the participants in the study was associated with risk more than any other factor. English language ability likely affects all of the other factors, such as job quality, insurance status, or acculturation level. However, lack of proficiency in English continues to be a protective factor for Latino immigrants against mental health problems.

Barriers to Mental Health Care/Reasons for Underutilization

Latino immigrants to the USA have been documented to underuse mental health resources in this country, which poses many questions as to why, as well as has prompted research into the reasons for this underuse (Alegria et al., 2007). Research has shown that one of the barriers to the Latino population receiving mental health care is that the mental health care system in the USA is unequipped to properly treat the Latino population and that this is a primary reason for the underutilization of services by this population (Rogler, 1996). There is currently a lack of bilingual service providers, as well as a lack of mental health providers being Latino themselves. A 1999 study by the Center for Mental Health Service found that for every 100,000 Latinos in the USA population there are 29 mental health professionals identifying as Latino themselves (Center for Mental Health Service [CMHS], 1999, as cited in US Department of Health and Human Services (USDHHS), 2001). In general Latinos have been found to be less likely to pursue outpatient care or counseling and psychotherapy compared to non-Latino White people (Pérez & Fortuna, 2005). Furthermore, due to acculturation and language barriers discussed above, Latinos may be unfamiliar with mental health services and may have

different perceptions of these services, which can impede their entrance and retention in mental health services (Rosado and Elias, 1993).

In Alegría et al. (2007) the authors describe the need for more data regarding the baseline levels of mental health needs in the Latino population in the United States of America so that more can be understood regarding the needs of these people. The authors also state that “One important priority in the nation’s research agenda is to assess the prevalence of mental illness and service use for Latinos and Asians in the US” (p. 209). The authors assert that by understanding better the prevalence of mental illness and what services are being used more systemic changes can be made to gear treatment toward the needs of the people living in this country. The authors assert that by researching the factors relating to consumption of mental health services and cultural and immigration factors, these changes can begin to be made.

Education and economic issues also heavily contribute to a lack of utilization of mental health services in this population. Education rates of Latinos have been shown to be significantly lower than those of White Americans, with Latinos completing college at a rate of 9.7% and Whites doing so at a rate of 29.6% (Paris, Jr. et al, 2005). Furthermore, individuals of Mexican heritage have been found the least likely of all of the Latino groups to have graduated from high school or to have completed higher education (Marotta & Garcia, 2003). Due to lack of education as well as undocumented status in the USA, many Latinos cannot find sufficient work to support themselves or their families, are at risk for unfair treatment in the workplace, and cannot afford luxuries such as mental health care. Often, a job obtained by an undocumented Latino consists of odd hours and requires use of public or unreliable transportation as well, due to not owning a

vehicle (Pérez & Fortuna, 2005). This lack of transportation may also make it difficult to come in to a mental health agency. Finally, Rosado & Elias (1993) reported that Latinos living particularly in urban areas receive poor mental health services. Due to the nature of employment many Latinos work in, lack of insurance also prevents many individuals of this population from accessing mental health services. This lack of insurance stems from both immigration status issues and lack of citizenship, and the number of Latinos in the USA who receive medical benefits from their workplace is 43%, while 73% of White Americans receive medical benefits from their employer (Brown et al., 1999; as cited in USDHHS, 2001), and Latino children in the USA are also the least likely, when compared to Asian Americans, African Americans, and White Americans, to be insured. This was found true whether the child was a citizen of the USA or not (USDHHS, 2001). Alegría et al. (2007) report that 19.1% of Latinos without insurance utilize services, indicating that the need may be present although utilization is low.

There are also many systemic and cultural barriers affecting the utilization of mental health care services within the Latino population. These include: a stigma within the Latino community affecting one's personal willingness to seek mental health services for fear of embarrassment or judgment, a lack of bilingual and bicultural service providers, a lack of empirically supported treatments for use with this population, and a general lack of culturally sensitive services available to the community (Añez et al, 2005). Individuals of the undocumented Latino population may also experience a higher level of suspicion and fear surrounding seeking and consuming mental health services, due to their legal status in this country. They may have difficulty trusting the services offered to them and may also not offer a great deal of information for fear it can be used

against them (Rogler, 1996). It is important for mental health care providers to assist clients of this population in feeling safe and create a welcoming environment. Alegria et al. (2007) suggest that Latino immigrant clients in mental health service be informed and oriented early-on in treatment in order to provide empowerment and a comfortable and safe place to discuss their expectations of treatment in order to provide a better chance at retention and positive outcomes.

For these reasons, it is important to conduct research regarding mental health services for Latinos living in the USA, to continue to learn about the needs of this population, the barriers to receiving the care needed, and to make recommendations for future change.

Review on Culturally Competent (CC) Treatment for Latinos

The literature regarding culturally competent treatment for the Latino population is widely varied and authors do not agree on which are the most culturally sensitive and appropriate means of treating mental health issues in Latinos. Though much literature does exist, it has recently gained momentum in the mental health field (Rogler, 1996).

The American Psychological Association (APA) has outlined in its ethical guidelines characteristics of culturally sensitive psychologists. These include recognizing one's attitudes and beliefs regarding other cultures, recognizing the importance of understanding and sensitivity towards other cultures, recognizing the importance of conducting research with other cultures, striving to apply culturally appropriate skills in clinical practice, and supporting organizational change and policy development regarding other cultures. Psychologists should also receive formal training for work with individuals of other cultures (APA, 2002). These guidelines aid psychologists in being

aware that working with an individual from another culture requires sensitivity and also requires that an individual be trained and prepared for doing so.

Rosado and Elias (1993) discussed these ethical guidelines and posited that an ethical psychologist providing services to the Latino population should be “investigative, non-assumptive, and flexible” when working. These authors also described the concept of a “socio-cultural matrix” and stated that an ethical psychologist must look at the problems within this matrix, such as those mentioned above contributing to the particular difficulties of the Latino population in the USA. The authors also asserted that an ethical psychologist must consistently integrate new research on treatments as a means of continuing to remain culturally sensitive and understanding the worldview of a particular client. Finally, the authors also reported that psychological treatment should be conducted in the client’s native language, and reiterated that the treatment should be done in a present-time orientation before specific, long-term treatment goals are addressed with the client.

Regarding cultural sensitivity, Lu et al (2001) defined this term as “clinicians’ appropriate responses to clients’ needs as derived from culturally specific dispositions”. Acevedo-Polakovich et al (2007) wrote about culturally sensitive treatments specifically for Latinos, saying that providers to Latino individuals should understand Latino constructs and symptoms, possess knowledge regarding the current empirical measures and treatments used with this population, and should be able to appropriately diagnose an individual of the Latino population using this knowledge.

These cultural constructs common in the Latino population are important to know when one is providing treatment to a Latino individual. Añez et al (2005) outlined several

of the cultural constructs often valued in Latinos. These include *familismo* (a devotion to family and keeping familial relationships intact), *personalismo* (an interpersonal style involving friendliness and a level of intimacy in relationships), *respeto* (the value of respect of others, particularly authority figures), and *confianza* (the concept of earning the trust of another person before revealing intimate details or becoming close friends). Furthermore, the construct of “allocentrism” is highly regarded in the Latino culture. This means that clients are more likely to highly regard the interpersonal relationship with a psychologist and may tend to value the needs of family members above their own. A psychologist will need to take care to respect the values of the individual while understanding the vast differences in cultural values that may exist.

A common misconception among psychologists who treat individuals that speak a language other than English as a primary language is that if treatment is conducted in the individual’s native language it should be considered culturally competent. Castaño, Biever, González, & Anderson (2007) asserted that cultural competence involves understanding the concepts and structures of the culture in question as well. This will help the therapist understand the client more and be able to provide the best treatment possible.

Due to the many daily stressors of undocumented immigrants and migrants to the USA, it is often difficult to conduct traditional psychotherapy. Rosado & Elias (1993) coined the term “social survivalism” to describe these daily struggles, which include finding housing, employment, insurance and medical care, means of transportation and obtaining food, and daily difficulties in adjusting to American culture. The authors posited that in mental health treatment with this population a “present-time” orientation is

often necessary, as a means of providing support and resources for the momentary needs of these clients. It is recommended that Latinos seeking mental health services be provided with practical skills and strategies for managing daily life before psychotherapy becomes deeper. Along with this idea, the authors defined the term “social-ecological view of mental health”, which they stated as “the opportunity to acquire skills for self-development in the presence of social support” (Rosado & Elias, 1993). With the Latino population, it will frequently be important to assist the client in taking care of immediate needs using support and giving resources.

Review on Evaluating Mental Health Services for Latinos

The evaluation of mental health services has increased in frequency. The effectiveness, rather than the efficacy, of the treatment is the more important factor indicating the validity of a specific treatment (Mezzich, Ruiz, & Muñoz, 1999). Efficacy refers to how well an intervention works in the context of the experimental clinical trial, while effectiveness is measured by how well the same intervention works in the general population, outside of the sterile experimental environment (Pittler & White, 2008). There is currently very little research regarding interventions used and treatment services for Latinos. For this reason, it is important to gain knowledge about these services, who is utilizing them, which diagnoses are most common, and what works or does not work when treating Latino individuals (Bernal and Scharren-del-rio, 2001, as cited in Frew and Thomas, 2008).

Suggestions have been made regarding future directions for mental health services for Latinos. Rosado & Elias (1993) asserted that the social-ecological models described above should be used by mental health providers in order to improve the therapeutic

relationship and create more culturally relevant treatment plans for use with Latinos. The authors also discussed the importance of integrating services to make them more culturally appropriate and available to those of lower socio-economic status. They recommended that organizations implement clinical outreach teams in order to create a network to achieve this integration. Finally, the authors stressed the importance of culturally sensitive and bilingual providers in order to overcome the language barrier as well as acculturative issues that are frequently faced by Latino clients.

Mezzich, Ruiz, & Muñoz (1999) also stated that providing clients with bilingual treatment is essential in working with this population. They also asserted that a biopsychosocial model is important in providing comprehensive and culturally sensitive, context-driven treatment for Latinos, as well as providing culturally sensitive clinical decisions and utilizing valid and reliable assessment measures. This biopsychosocial model involves integration of psychiatric providers as well as involving the client's family and community in treatment to the extent that this is possible.

Description of Current Study

This dissertation is based on a research study by Pérez & Fortuna (2005), in which descriptions of both documented and undocumented clients at a community mental health center were compared. The purpose of this study was to describe the patterns of mental health care use at this particular site, including the appointments attended and the history of treatment of the clients, with the objective of providing recommendations for further services to undocumented individuals, especially to improve the retention rates in treatment.

Pérez & Fortuna (2005) found that the undocumented population was more likely to receive a diagnosis of anxiety, Adjustment Disorder, or Alcohol Abuse, to experience a great number of psychosocial stressors, and to attend fewer total mental health appointments. Clients of undocumented status tend to be seen less frequently and for shorter durations of treatment. It was also found that these clients report greater satisfaction with services that integrate and are easily accessed in one place, coordinating resources and working together to ensure the client receives all of the services necessary. The authors stressed the importance of focusing on early assessment for undocumented Latinos, the consistent presence of a great number of psychosocial stressors, and barriers to care. They posited that it is important when working with undocumented clients to focus on these culture-specific stressors and to be an advocate for changing policies that are not helpful to this population. They also asserted that clients should be treated in a directive manner aimed at solving problems and educating the individual, and clients will respond favorably to this. They also recommend that the mental health provider consider the various factors affecting the client's problem, especially cultural, systemic, and environmental ones. Finally, the authors stated that the mental health provider should be aware of the barriers existing to Latinos in the USA and should anticipate the problems associated with this, working as efficiently as possible given the difficulties. As a result, the authors asserted that it is important to be involved in policy change and legislation to change the way the system operates (Pérez & Fortuna, 2005).

This dissertation examined the archived charts of 100 Latino individuals who received mental health services at a community-based Latino mental health program in Portland, Oregon. The MIOS Program, a part of Cascadia Behavioral Healthcare until

July, 2008, served un-insured, Spanish speaking, Latino individuals in Multnomah County. Throughout this partnership, Cascadia Behavioral Health Care provided clinical and fiscal oversight of the MIOS program. The MIOS program was funded by Multnomah County, with culture-specific mental health funds. During its partnership with Cascadia, the MIOS Program provided psychotherapy and case management services to these Latino individuals, as well as medication management through a Spanish speaking psychiatrist. The MIOS model was to base the mental health professional in an accessible position in the community, rather than being confined to mental health centers or clinics. Specifically, the model of the MIOS program was to integrate “evidence-based approaches and cultural knowledge in the context of the bio-psycho-social model in order to meet clients’ needs adequately and effectively” (MIOS Program, 2008, p. 1). The MIOS Program provided mental health therapy in the form of cognitive-behavioral interventions, solution-focused brief therapy, structural family therapy, and psycho-education, as well as providing parenting skills and psycho-educational manualized trauma recovery groups for Spanish-speaking women. MIOS provided outreach to the community and enrolled clients through a telephone line called Teléfono Amigo, which received approximately 40 calls a month, both from potential clients themselves and providers in the community looking to refer (MIOS Program, 2008). Due to several extraneous reasons, the MIOS program ended its partnership with the parent program of Cascadia Behavioral Healthcare; thus, this study is being conducted to help inform the design of future mental health programs serving the Latino population in the USA.

As Pérez & Fortuna (2005) found, very little is known about the patterns of mental health use, the diagnoses that are common to this population, and which types of psychosocial problems are most commonly found among this undocumented group of Latinos. Furthermore, they stated that “Conducting localized needs assessment studies can be extremely beneficial for culturally sensitive program development.”, while Keefe & Casas (1980) posited that improvement of service delivery should be a focus for mental health programs. Finally, Mezzich, Ruiz, & Muñoz, (1999), along with their assertion of the importance of the biopsychosocial model and the importance of integrating services, stated that it is important to collect data regarding services in order to assess the availability of clinical services. The authors stated that research involving mental health policy and service delivery is essential in order to create progress in the quality of mental health care offered to Latinos. They noted the urgency of the necessity for this research due to the increasing demand for services to this population.

This service utilization study provides demographic information about the Latino clients who received services within the MIOS Program within this time frame, as well as describes the patterns of treatment. Finally, recommendations are made for future community mental health services. By conducting this research project to describe these patterns within the MIOS program, further knowledge can be gained about the efficiency of this treatment and needs for change in future community mental health care programs serving Latino individuals.

METHOD

Setting and Sample

Using a systematic utilization review design, a clinical chart review was conducted using 100 randomly selected, closed charts of MIOS clients seen between the years of 2003-2008. These closed, archived charts were organized in different boxes by first letter of last name but not in any specific order. Charts were randomly pulled from boxes. If the chart was of a minor or an individual with insurance it was set aside and not used in the study. This process continued until 100 charts were reviewed. Approval was obtained from Cascadia Behavioral Healthcare to conduct this investigation, and approval was also obtained from the Pacific University Institutional Review Board to conduct this research prior to beginning the chart review. The MIOS program, while under the clinical oversight of Cascadia Behavioral Healthcare, provided outpatient mental health and psychiatric services to monolingual Spanish-speaking Latino individuals, approximately 90% without health insurance. Clients that had some level of insurance (Oregon Health Plan, Medicare, etc) were excluded from this study. In order to help inform the design of future successful mental health programs for this population, this systematic utilization review will (1) count and classify the use of the services within the MIOS program during this time, and (2) identify and describe the services used, and the demographics of the clients using these services.

Confidentiality was protected using an anonymous numbering system that pairs client data with a specific chart. No client names were used in this study, and no other identifying information is associated with data. This analysis consists of categorization of

data in order to provide an overall picture of the clientele receiving services at the MIOS program.

The sample in this study consists of adult, monolingual Spanish-speaking individuals living in Multnomah County in Oregon. Youth charts were excluded from this study. These individuals received mental health and/or psychiatric services within the MIOS program during its partnership with Cascadia Behavioral Healthcare. The mental health services provided within the MIOS program consisted of outpatient psychotherapy for individuals, families, children, adults, and groups, and case management in the form of connecting clients with resources in the community. This program also provided psychiatric evaluations and medication management through a psychiatrist staffed in the MIOS program. The MIOS program telephone referral line, Teléfono Amigo, brought clients into the program by means of a qualified mental health assistant or qualified mental health provider who conducted phone screens and scheduled appointments for clients in one of the three sites of the MIOS program. These three sites were housed in community mental health centers and community-based organizations providing services to Latinos in the Multnomah County area, consistent with the MIOS program philosophy of placing the mental health professional in accessible places to the client. General information will be provided about all of the clients who received treatment at the MIOS program, and the information gathered from the variables listed below will be gathered from adult charts only.

Several variables were reviewed and described in this study:

- *Age*. The birth date of the individual was recorded using information from the client's intake paperwork.

- *Date service initiated.* The date of the client's intake appointment was recorded using information from the client's intake paperwork.
- *Length of treatment.* The number of sessions attended was recorded, as well as the number of weeks the client was enrolled in the program. Information was obtained from reports and progress notes in the chart. The ratio of number of sessions to number of weeks enrolled in the MIOS program was calculated.
- *Gender.* Clients were classified as male, female, or other. The information was recorded using the intake paperwork from the client's chart.
- *Medical conditions.* Medical conditions listed on Axis III were recorded as yes or no. This was determined by the intake report in the client's chart.
- *Primary Language.* The client's primary language was recorded as English, Spanish, Indigenous, or other. This was determined using information in the client's intake paperwork.
- *Religion/Spiritual Connection.* The client's identification with a religion or a spiritual connection was recorded as yes or no, based on information from the intake report in the client's chart.
- *Axis I Diagnosis.* The DSM-IV TR Axis I diagnosis given to the client at intake was recorded using the intake report in the individual's chart.
- *V-codes.* Any V-codes from the DSM-IV TR received at intake was recorded in a yes or no format.
- *Use of Psychiatrist Services.* Whether or not the client received medication prescription from the MIOS psychiatrist at some point in his or her treatment was recorded in a yes or no format.

- *Percentage of Clinical Appointments Kept.* The ratio of appointments kept/appointments given was calculated for each individual
- *Country of origin.* Each individual's country of origin was recorded using information from the client's intake report in the chart.
- *Suicidality.* Past and current suicidal ideation was recorded using information from the client's intake report in the chart.
- *Substance Abuse.* Substance abuse was documented by whether the client was given a DSM-IV TR substance abuse diagnosis during treatment. This information was taken from the client's intake report in the chart. It was recorded in a yes or no format.
- *Severity of Illness at Intake.* The severity of illness at intake was recorded using the Global Assessment of Functioning (GAF) score from the client's intake report in the chart. The GAF scale is a 0-100 point scale that offers a global way to track clinical progress of clients, with 100 being the highest functioning.
- *Severity of Illness at Termination.* The severity of illness at termination was recorded using the GAF score from the client's termination summary in the chart.
- *Psychosocial Stressors.* Psychosocial stressors were recorded using the DSM-IV TR categories of Problems with Primary Support Group, Problems Related to the Social Environment, Educational Problems, Occupational Problems, Housing Problems, Economic Problems, Problems with Access to Health Care Services, Problems Related to Interaction with the Legal System/Crime, and Other Psychosocial and Environmental Problems. The total number of psychosocial

stressors were also recorded for each individual. This information was recorded from the intake report in the client's chart.

- *Prior Mental Health Use.* Any prior mental health treatment was recorded in a yes or no format using information from the client's chart.
- *Trauma History and Type.* Any trauma history was recorded as sexual, physical, having witnessed a traumatic event, trauma related to border crossing into the USA, a combination of these, or none. This information was gathered from the client's chart.
- *Involvement with Department of Human Services.* Any legal involvement with the Department of Human Services was recorded in a yes or no format using information from the client's chart.
- *Time in the USA.* The number of years the individual had been in the USA at time of intake was recorded using information from the client's chart.
- *Age of Migration.* If foreign-born, the age of migration to the USA was recorded using information from the client's chart.
- *Referral Source.* It was indicated whether the client was referred from DHS, self-referred, from a friend or family member, or from another community organization.

By reviewing the chart information for these individuals, examining these variables, and describing the services used at the MIOS program, recommendations can be given for specific services needed within this population. Specifically, to make this study most useful for future planning of services, the primary analysis consisted of enumerating the variables associated with type and severity of mental disorder or reason for requesting

services. These were then further explicated through examination of such factors such as type of stressors present for the most common disorders, type of services received, and support factors such as family and religion. In addition to reviewing the client's individual charts, descriptive information was gathered, including the total number of enrolled clients in the MIOS program during its partnership with Cascadia Behavioral Healthcare, the gender and age demographics of all of the clients seen at MIOS during this time, the number of individuals given each diagnosis, and the mean number of sessions overall. This information will be gathered using data from a recent proposal. The questions asked in this study were: (a) What were the primary diagnoses given to the clients at the MIOS program during this time?; (b) What were the most common psychosocial stressors of the clients at the MIOS program during this time?; (c) What are the demographics of those who received treatment, i.e., gender, age, primary language; and (d) How long did treatment typically last?

RESULTS

Frequency analyses were completed for the continuous variables of gender, sexual preference, ethnicity, sessions attended, length of treatment, medical conditions, language demographics, financial responsibility for others, religious preference, psychiatric services received, country of origin and time in the USA, suicidality, previous mental health received, type of trauma history, involvement with DHS, and referral source of participants. The analysis corresponds to the total number of charts that were reviewed (N=100).

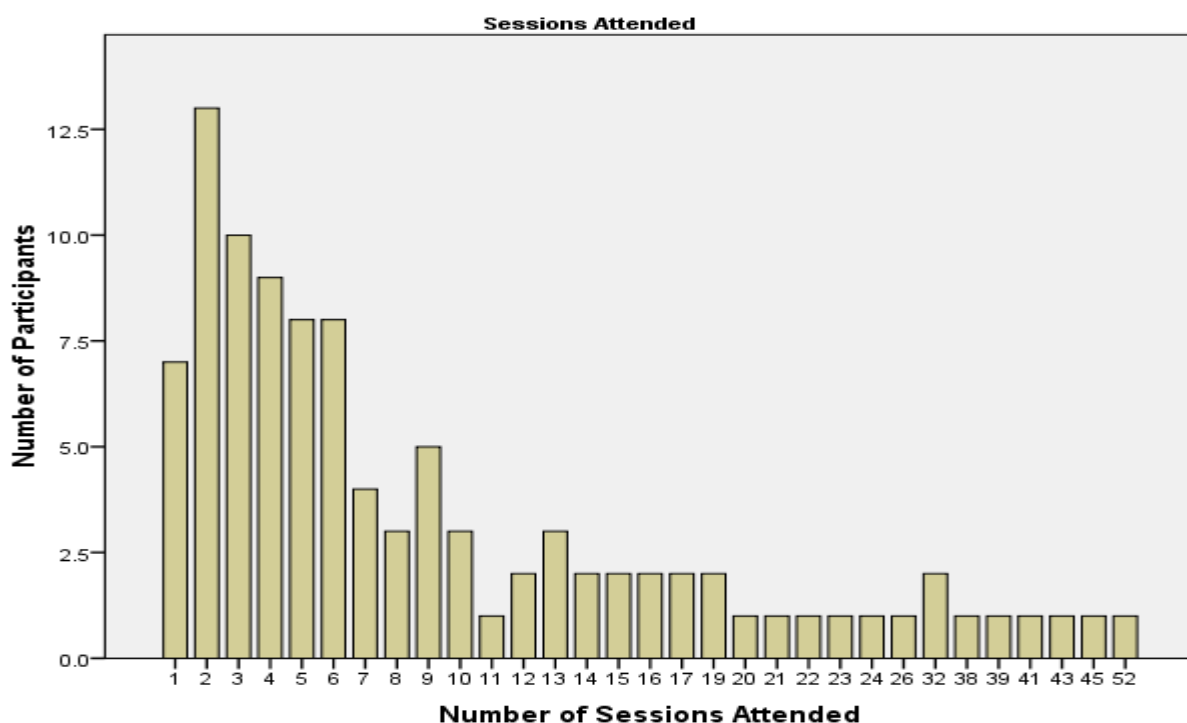
Demographics and Characteristics of the Study Participants

The MIOS Program, while a part of Cascadia Behavioral Healthcare, enrolled a total of 906 clients. Of these, 187 were children under the age of 18. Of the remaining 719 clients, 484 were female and 231 were male. Based on this information, the sample of 100 randomly chosen files appears to be a good representation of the adult clientele seen through this program.

The mean age of adult clients in the sample who received treatment through the MIOS Program was 34.5 years (SD = 9.75), with a minimum of 18 years and a maximum of 68 years. There were a higher percentage of females receiving services in the sample than males (Females = 68%, N=68); Males = 32%, N=32). Ninety-eight percent (N=98) of the participants reported heterosexuality and two percent (N=2) reported homosexuality. Twenty-five percent of the sample was referred to the MIOS Program by a friend or family member (N=25), eight percent was referred by the Department of Human Services (N=8), and 67% was referred by another source. The number of sessions attended had a mean of 45% and the mean number of sessions attended was 10 (SD =

10.85). The minimum number of sessions attended was 1 (N=7) and the maximum number of sessions attended was 52 (N=1). The modal number of sessions attended was 2 (N=13). More information on sessions attended is presented in Figure 1.

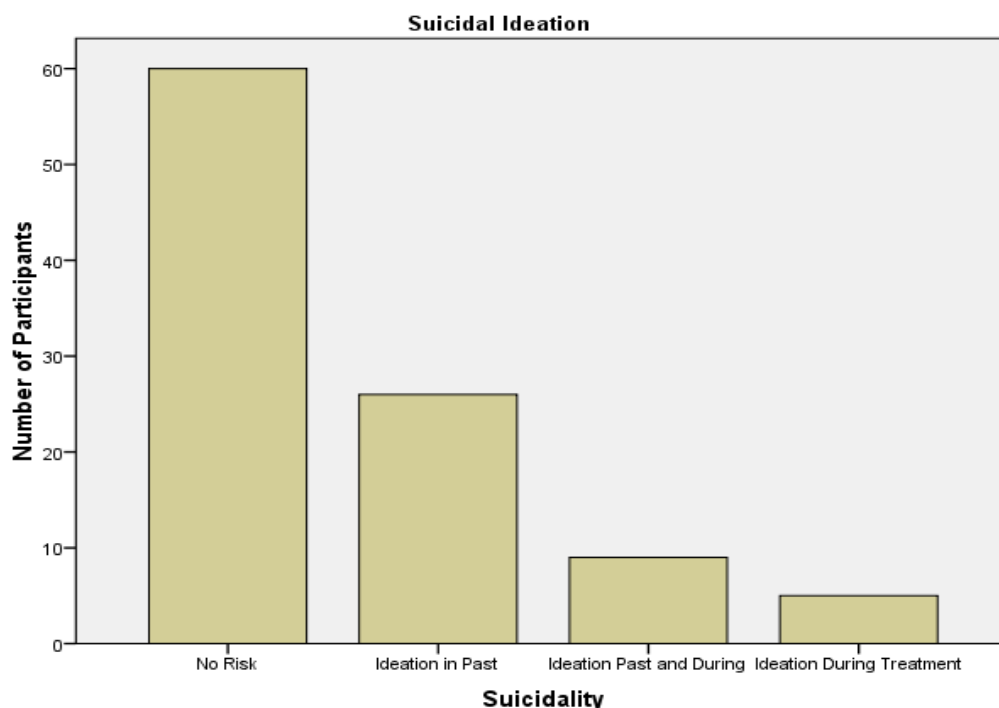
Figure 1 *Number of sessions attended*



Fifty-two percent of the participants had a medical condition listed on Axis III (N=52), and 37% of the participants in the sample received psychiatric services through the MIOS Program during their time enrolled (N=37). The majority of participants (60%, N=60) reported no history of suicidal risk either before or during their treatment with the MIOS Program, while 26% (N=26) had past suicidal ideation noted from the time before they were in treatment at the MIOS Program, nine percent (N=9) experienced suicidal ideation both in the past and during their treatment with MIOS, and five percent (N=5)

indicated they had not experienced suicidal ideation in the past but did experience this during their time enrolled in the program. This information is presented in Figure 2.

Figure 2 *Suicidal ideation in participants*

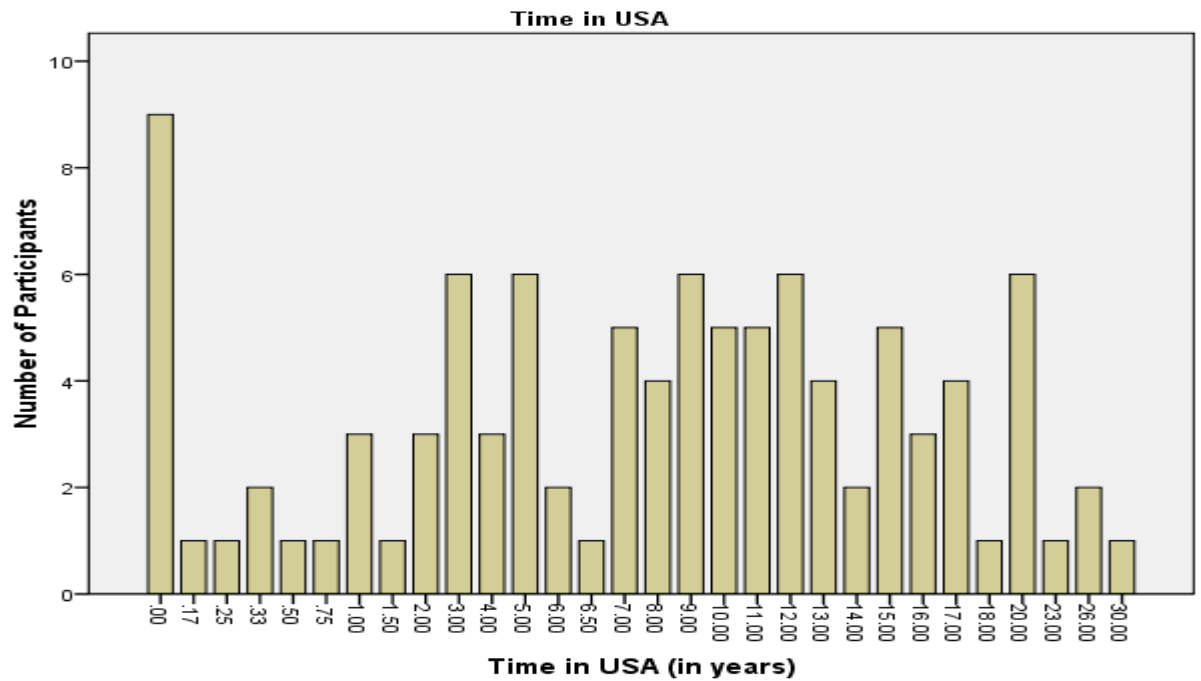


Fifty-seven percent (N=57) of individuals in the sample had received some previous mental health services, including in their country of origin and within the United States. Twelve percent (N=12) of the participants were involved with the Oregon Department of Human Services at the time of enrollment into the MIOS Program.

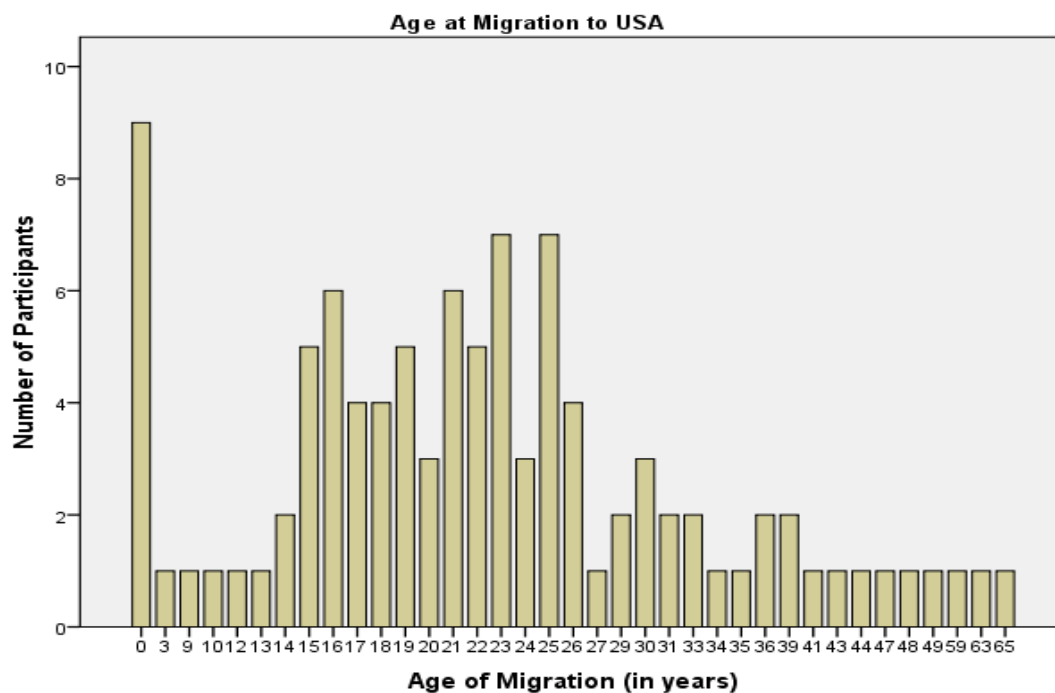
Cultural and Immigration Demographics

Eighty-eight percent (N=88) of the sample did not speak English at the time of intake, while 12% (N=12) had some English speaking ability. The most common primary language of participants was Spanish (93%, N=93) and other indigenous languages comprised the remaining seven percent (N=7). It is important to note that not all of the charts indicated specifically whether the individual's primary language was an

indigenous language, so this number could be higher. Regarding religious and spiritual preferences, 76% of the sample reported they consider him or herself a religious person (N=76), 23% reported they did not consider him or herself a religious person (N=23), and one percent (N=1) did not indicate in the intake report his or her religious preference. Eighty-four percent of the participants were Mexican in ethnicity (N=84), while 10% (N=10) were found to be from other Central American countries such as Ecuador, El Salvador, Nicaragua, and Honduras, and three percent (N=3) from other Spanish-speaking countries, which were noted as Cuba, Costa Rica, and Puerto Rico. The mean number of years the sample had been in the USA was nine (SD = 6.96). See Figure 3 for information regarding time in the USA.

Figure 3 *Number of years living in USA*

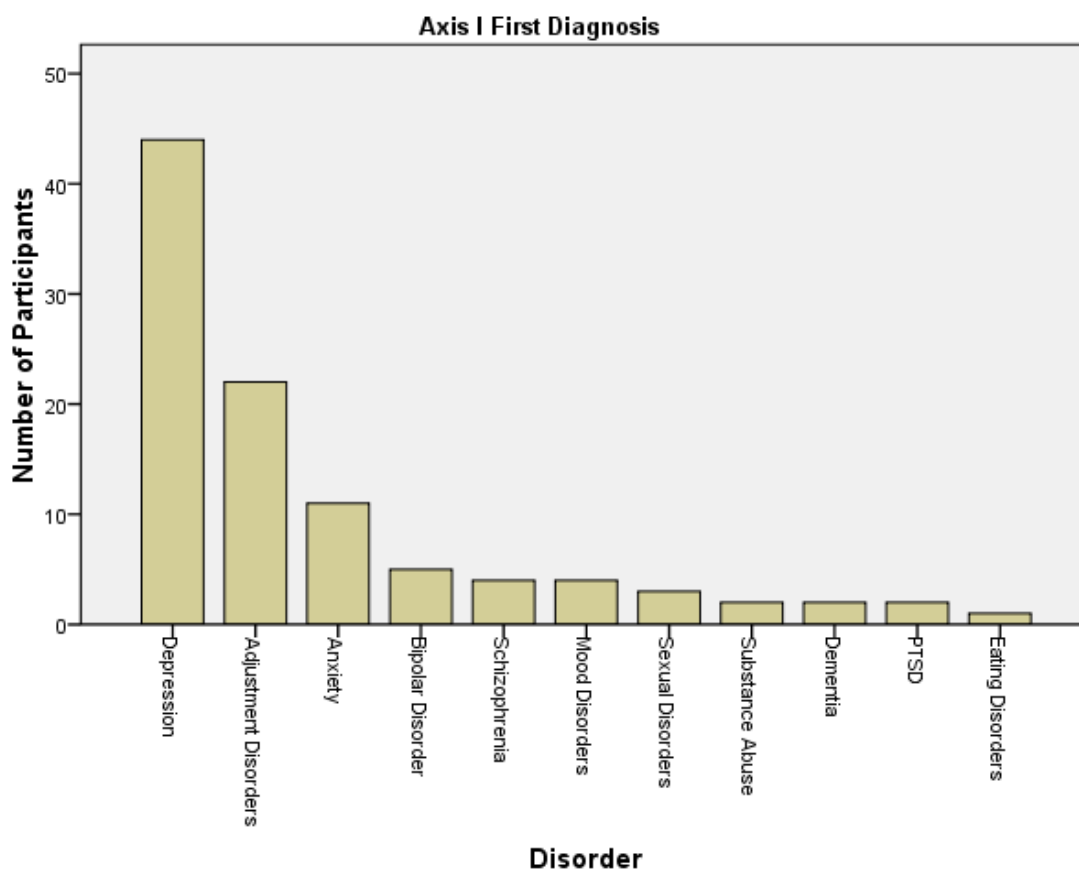
The mean age of migration to the USA in this sample was 22 years ($N=5$, $SD = 12.84$). Information regarding age of migration of the sample to the USA is presented below in Figure 4. Nine of the charts did not have information regarding the age of migration or number of years in the USA. However, due to the fact that country of origin was indicated in all of the charts, we can infer that none of the participants in this sample were born in the USA.

Figure 4 *Age of migration to the USA*

Distribution of Diagnoses

Figure 5 shows the distribution of diagnoses as broken down into diagnostic category. These are the first diagnoses listed on Axis I in the intake report.

Figure 5 *Breakdown of Axis I Diagnoses*

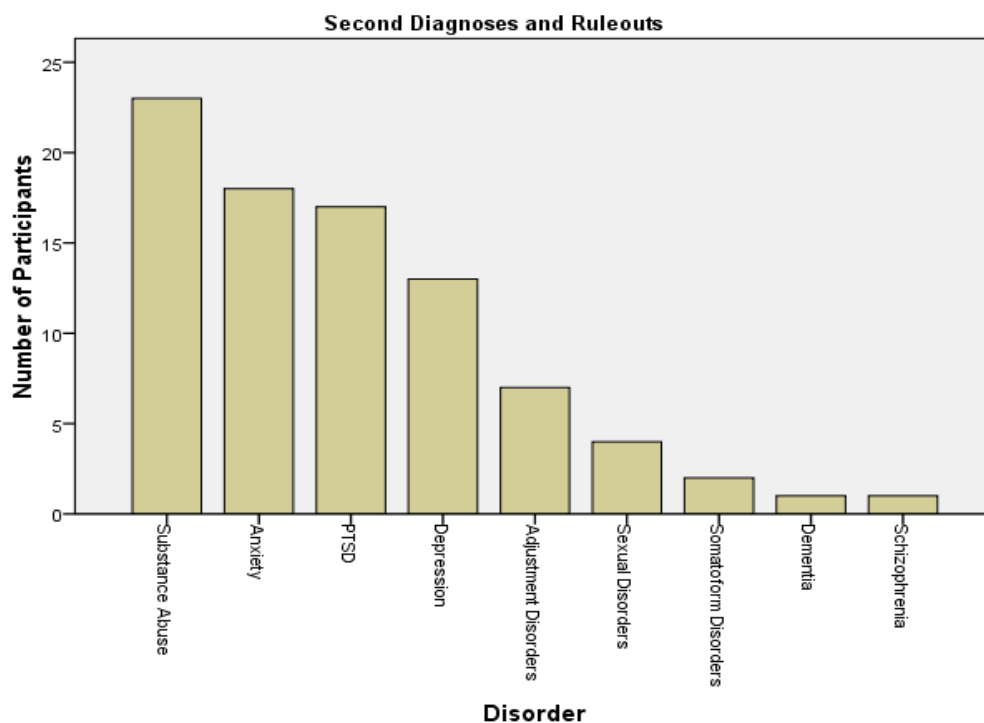


Forty-four percent of the sample (N=44) had a diagnosis of Depression, including Major Depressive Disorder and Depressive Disorder NOS. The next most common diagnosis was Adjustment Disorders (22%, N=22). Other first diagnoses listed on Axis I were Substance Abuse Disorders, Dementia, Schizophrenia spectrum disorders, Bipolar Disorder, other Mood Disorders, Anxiety spectrum disorders, eating disorders, Post Traumatic Stress Disorder, and Sexual Disorders. Table 1 shows the distribution of these.

Table 1 *Axis I First Diagnosis Breakdown*

Axis I First Diagnoses	Sample (N=100)
Substance Abuse	2 (2%)
Dementia	2 (2%)
Schizophrenia	4 (4%)
Depression	44 (44%)
Bipolar Disorder	5 (5%)
Mood Disorders	4 (4%)
Anxiety Disorders	11 (11%)
Eating Disorders	1 (1%)
Adjustment Disorders	22 (22%)
PTSD	2 (2%)
Sexual Disorders	3 (3%)

Figure 6 shows the distribution of second diagnoses listed on the intake report, as well as ruleouts listed on the intake report. This information was collected to obtain a picture of secondary common diagnoses.

Figure 6 *Breakdown of Second Diagnoses and Ruleouts*

A chi-square test for independence was done to determine any relationship between the variables of gender and diagnoses of Depression, Anxiety, and Adjustment Disorders, as these were found to be the most common diagnoses. It was found that the proportion of distribution of gender across these diagnoses was contrary to what would be expected by chance ($\chi^2 (2, N=77) = 8.61, p = <.05$). Men differed from women in all three of these categories, being more likely to have a diagnosis of Adjustment Disorder than women and less likely to have a diagnosis of Depression or Anxiety Disorder. A table displaying these numbers is below.

Table 2 *Gender and Diagnosis*

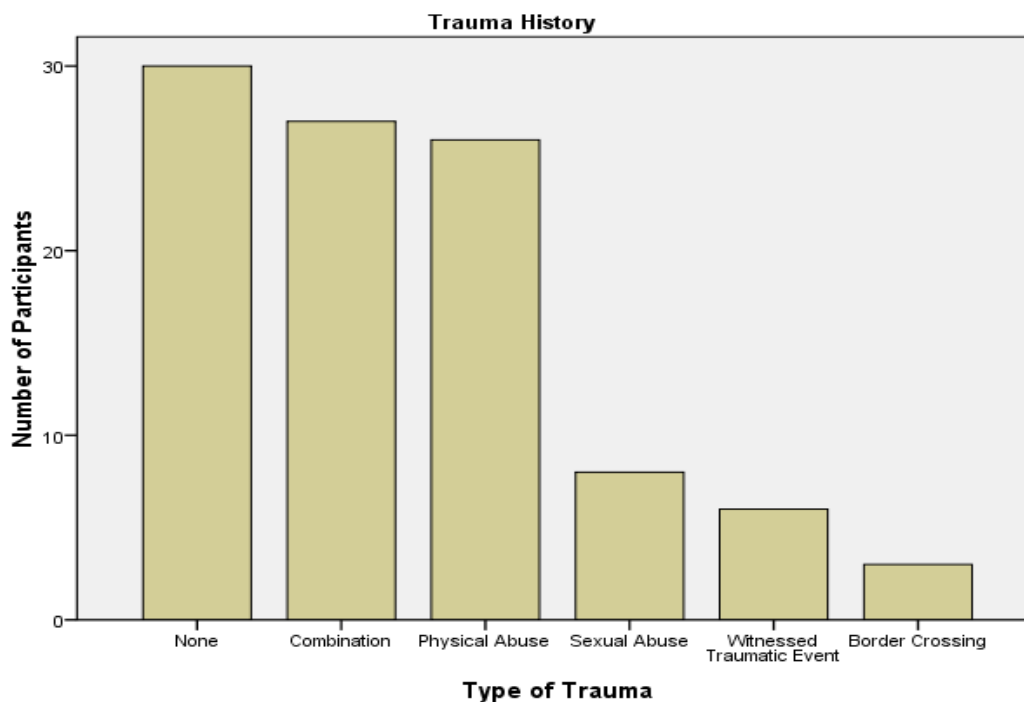
	Depression	Anxiety	Adjustment	Total
Male	7 (38.9%)	1 (5.6%)	10 (55.6%)	18 (100%)
Female	37 (62.7%)	10 (16.9%)	12 (20.3%)	57 (100%)
Total	44	11	22	77

Eighty-five of the participants in the sample had a second diagnosis and/or ruleouts. Of these 85, 27.1% had a second diagnosis or ruleout of a Substance Abuse disorder (N=23), 20% had an Anxiety Disorder second diagnosis or ruleout (N=17), and 20% had a second diagnosis or ruleout of PTSD (N=17). Other second diagnoses or ruleouts listed on the intake report included Dementia, Schizophrenia, Depression, Adjustment Disorder, Sexual Disorders, and Somatoform Disorders. Table 3 shows a distribution of these.

Table 3 *Axis I Second Diagnoses or Ruleouts*

Axis I Second Diagnoses or ruleouts	Sample (N=85)
Substance Abuse	23 (27.1%)
Dementia	1 (1.2%)
Schizophrenia	1 (1.2%)
Depression	14 (16.5%)
Anxiety	17 (20%)
Adjustment Disorder	7 (8.2%)
PTSD	17 (20%)
Sexual Disorder	3 (3.5%)
Somatoform Disorder	2 (2.4%)

A diagnosis of Posttraumatic Stress Disorder was given to 19 individuals total (19% of the sample) as a first diagnosis, a second diagnosis, or a ruleout. Furthermore, statistics on type of trauma indicated on the intake report were collected. Figure 7 shows the breakdown of trauma experienced in the sample.

Figure 7 *Type of Trauma Experienced*

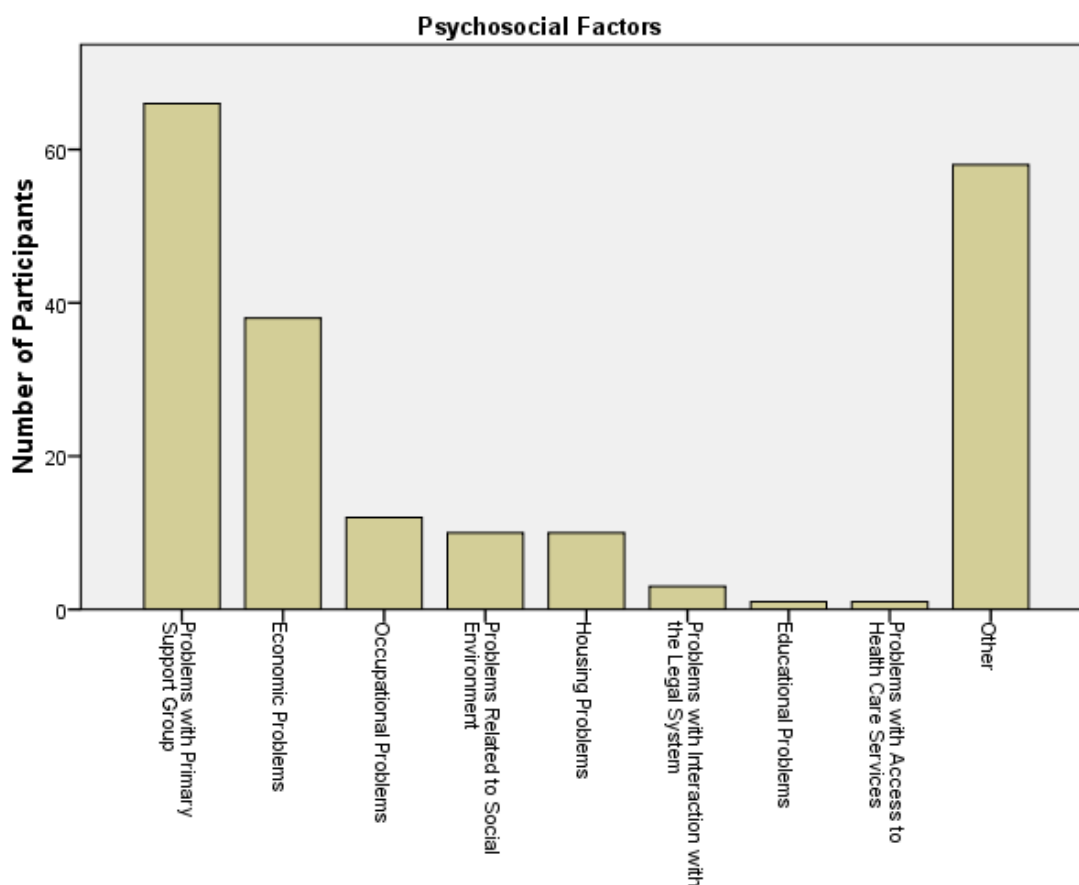
Twenty-seven percent (N=27) of the sample had experienced some combination of sexual abuse, physical abuse, witnessing a traumatic event, or trauma associated with immigration or crossing the border. Physical abuse alone was reported in 26% (N=26) of the sample, sexual abuse alone was reported in eight percent (N=8) of the sample, witnessing a traumatic event alone was reported in six percent (N=6) of the sample, and trauma related to immigration or crossing the border alone was reported at three percent (N=3). Thirty percent (N=30) of the sample was reported to not have experienced any trauma.

Six participants in the sample were given an Axis II Diagnosis. These included Histrionic Disorder (1%, N=1), Antisocial Personality Disorder (2%, N=2), Borderline Personality Disorder (2%, N=2), and Moderate Mental Retardation (1%, N=1).

Psychosocial Factors

Psychosocial factors listed on Axis IV of the intake report were recorded for each participant. Figure 8 displays the breakdown of psychosocial factors (N=199).

Figure 8 *Breakdown of Psychosocial Factors*



The most common psychosocial factor listed was Problems with Primary Support Group (33%, N=66). This was followed by Economic Problems (19%, N=38), Occupational Problems (6%, N=12), Problems Related to the Social Environment (5%, N=10), Housing Problems (5%, N=10), Problems with Interaction with the Legal System (1.5%, N=3), Educational Problems (.5%, N=1), and Problems with Access to Health Care Services (.5%, N=1). The “Other” category included psychosocial problems that

were listed on Axis IV but not under any of the DSM-IV TR specific categories. These included acculturation problems, language barriers, recent move to the USA, immigration issues, lack of resources, separation from family, and recent hospitalizations (29%, N=58).

DISCUSSION

The major aim of this dissertation was to describe the population that was served at the MIOS Program during its time as a part of Cascadia Behavioral Healthcare. In particular, attention was focused on the mental health and psychosocial problems these individuals experienced which were focused on during treatment with the MIOS Program. With this information, recommendations can be made for further services for this population in the Portland, Oregon metropolitan area.

All of the participants in the sample were foreign-born and had a primary language other than English, consistent with the MIOS Program's mission to serve Spanish-speaking individuals. This finding reiterates the importance of providing Spanish-speaking mental health services in this area, and the finding that all participants were foreign-born highlights the importance of providing culturally competent care to these individuals. Seven of the participants in the study reported a primary language that was indigenous to their area of origin. These included the languages of Mixteco and Tarasco. Because this was not a specific question on the intake report, it is possible there are others who speak a language other than Spanish as their primary language. This suggests that many immigrants to the USA may have an extra layer of difficulty in communicating, even with a Spanish-speaking mental health therapist. In these situations, although a therapist who speaks these indigenous languages would be ideal, it is not likely many exist. A Spanish-speaking therapist would be essential in providing the most competent services possible.

The high percentage of women receiving mental health services compared to men may be explained by the stigma described above (Añez et al, 2005), in which receiving

mental health care is considered a sign of weakness in the Latino population. This finding may also be explained by the fact that men are more likely to work during the day while women stay at home with children, creating another barrier to men seeking mental health services. Additionally, the high percentage of heterosexuality compared to homosexuality may be explained by the fact that many Latinos, specifically Mexicans, are likely to have beliefs based on the tenants of the Catholic Church and other Christian religions, which historically and currently does not accept homosexuality as a way of life. It may be that some are not reporting homosexuality because of this.

As would be expected given the demographics of Latinos living in the Northwest section of the USA, 84% of the sample was Mexican born. This reflects immigration patterns into the USA from México (Reséndiz Arroyo, 2008). Mental health service providers should be culturally competent regarding the Mexican culture and be knowledgeable about the experiences of immigration from México to the USA. The many complex factors that are involved in an immigrant's life in the USA are important to take into account when working with this population in therapy.

Because the modal number of sessions attended in this sample was two, it should be noted that the barriers to treatment listed above likely account for many of these individuals not returning for more sessions. Transportation, economic issues, and lack of childcare may be reasons for not attending more sessions. In completing the data collection for this study, it was informally noted that many individuals missed sessions for reasons such as not having childcare and transportation problems. Furthermore, although no official data was collected on case management, it was noted that case management (phone calls, finding resources for the client, informal sessions to discuss

paperwork and coordinate services) was very common in the sample. Although an individual may have only come for two official therapy sessions, it is likely they were enrolled in the MIOS Program for a long period of time and received a great deal of case management. Another factor in this is that some individuals were considered “medication only” clients and did not come to therapy sessions other than the intake and annual update sessions. A further observation noted by Pérez and Fortuna (2005) is that Latino clients often have little knowledge or experience of the mental health system in the USA. This fact may lead Latinos to not understand the overall process of therapy. Pérez and Fortuna also reported that undocumented Latinos receiving mental health treatment responded more to a “direct, problem-solving, supportive and informative approach” to mental health services (pp 118-119). Once a Latino client feels an immediate relief of symptoms they may be more likely not to return to services. This speaks to the idea of making therapy oriented to the present time, as discussed earlier, in Rosado & Elias (1993). It is important for a therapist to deal with the current issues of a client before moving on to deeper ones, as he or she may not be present for a great number of sessions.

More than half of the participants were reported to have one or more medical conditions on Axis III on the intake report. This large percentage may be a result of the fact that all of the clients at the MIOS Program were uninsured, causing the participants in the sample to delay seeing a doctor for medical issues. Some of these medical problems may also be related to stress of a mental health problem, as it has been reported that Latinos are particularly more likely to experience physical symptoms in response to stress.

Seventy-four percent of the sample was found to be responsible financially for others. This included clients with children or those who had taken in recently immigrated family members or friends. This is an example of the complexity of the immigration situation and further cultural factors that contribute to mental health issues in this population.

Although specific religious denomination was not collected in this study, 77% of the participants reported being a religious or spiritual person. A culturally competent mental health therapist will also need to explore the meaning religion or spirituality may have for each client. Once these are determined, the therapist must take into account the religious and spiritual factors that are prevalent in this population and incorporate these into treatment. Doing so will aid in joining with the individual in a positive therapeutic relationship as well as likely aid in the reaching of therapeutic goals for the individual.

Depression and Adjustment Disorders were found to be the most common among this sample, which is consistent with the findings of the undocumented individuals in Pérez and Fortuna's 2005 study. Adjustment Disorders are likely seen at a high rate due to the many factors involved in immigration and establishing identity in a new country. These factors along with the psychosocial barriers faced by immigrants also likely contribute to a high rate of Depression among the sample. As discussed above, Rosado and Elias (1993), Latinos in the USA face a great deal of economic, language barrier, discrimination, and educational stressors. The findings of these common diagnoses in this population are consistent with this.

It is noteworthy that 77% of the sample was diagnosed with one of the three disorders of Depression, an Anxiety Disorder, or Adjustment Disorder. Mental health

programs serving this population should have clinicians who are prepared to work with these three diagnoses and the cultural elements that accompany them.

Furthermore, Substance Abuse disorders were common as second diagnoses, concurrent with another Axis I disorder. Pérez and Fortuna (2005) also reported the undocumented in their sample had a high rate of substance abuse disorders. As a recommendation for working with these clients in a program that is not specifically focused on substance abuse problems, Pérez and Fortuna suggested education and information about resources as an important part of the treatment.

Anxiety Disorders were also prevalent among the sample, including Generalized Anxiety Disorder, Posttraumatic Stress Disorder, Panic Disorder, and Anxiety Disorder Not Otherwise Specified. Many incidents of Posttraumatic Stress Disorder were diagnosed, particularly for cases of physical and sexual abuse. Three diagnoses of PTSD were given following a traumatic experience that was reported to have occurred during the process of immigration or crossing the border into the USA. There may be more incidents of trauma related to immigration that were not diagnosed with PTSD, and this is an area that mental health providers should assess that is particular to this population and may affect functioning of an individual. Overall, approximately nine percent of individuals who experience some sort of trauma develop diagnosable Posttraumatic Stress Disorder, according to the 1999 Surgeon General's Report (APA, 2007). The number in this sample appears to be higher than this statistic, which could be due to clinician diagnosis error or an actual higher level of trauma in this population.

Personality disorders were diagnosed in five individuals, including Borderline Personality Disorder, Antisocial Personality Disorder, and Histrionic Personality

Disorder. Because many individuals did not come for more than a few sessions it is difficult to know how many of the sample may have actually had a personality disorder.

Psychosocial factors were listed for each individual on Axis IV of the intake report. Problems with Primary Support Group was the most common factor listed. This is not surprising, given the fact that many of these individuals are separated from their family members or experience strain in their relationships due to acculturation and adjustment factors. Pérez and Fortuna (2005) also list this as a common factor found among their undocumented sample. Following this factor were the psychosocial issues of Economic Problems, Occupational Problems, Problems Related to the Social Environment, Housing Problems, Problems Related to Interaction with the Legal System, Educational Problems, and Problems with Access to Health Care Services. Many “Other” psychosocial factors were listed on Axis IV in this sample, nearly all of which included problems related to acculturation. Specifically, these were listed as acculturation problems, language barriers, recent move to the USA, immigration issues, lack of resources, separation from family, and recent hospitalization. These factors are likely to contribute to mental health issues that are specific to this population and to create a more complex set of inter-related issues to work with in therapy. Also, as Pérez and Fortuna stated in their study, this population may make for an exceptionally difficult therapeutic process due to severe economic problems that are creating an immediate crisis for the client. Because of this, mental health providers may often find themselves working in a focus-driven way, looking for resources for the client and assisting in relieving the mental health symptoms that come up as a result of this economic stress. From this, it can be recommended that clinicians who are working with this population prepare to dedicate

more time than would be considered normal to case management, resource coordination, and solution-focused treatment solutions. As Rosado and Elias (1993) reported, a “present-time” orientation when working with Latinos in therapy may be the most beneficial. Similarly, twelve of the individuals in this study were legally involved with the Department of Human Services at the time of intake with the MIOS Program. Communicating with other care providers is essential in working with this population, to assist the client in accessing resources and facilitate gaining familiarity with various systems in the USA, similar to what is referred to in the literature as a “cultural broker”.

The mean number of years individuals had been living in the USA was nine, with fifteen individuals being in the country for less than one year. The mean age of migration in the sample was 22 years, with 31 individuals immigrating before the age of 18. Many of the individuals immigrating to the USA were raised in a different system with different cultural values and consequently will have difficulty becoming accustomed to and understanding the cultural norms and values of the USA. As mentioned above, Añez, Paris, Bedregal, Davidson, & Grilo (2005) and Pérez and Fortuna (2005) posited that stress associated with acculturation leads to a higher risk of experiencing mental health issues. Also, Mezzich, Ruiz, & Muñoz (1999) reported higher utilization of mental health services within this population due to acculturative stress. Furthermore, as Alegría et al. (2008) found, the immigrant paradox suggests the longer a person is in the USA after immigrating, the more mental health problems he or she tends to experience, particularly in the Mexican immigrant population. Specifically, in a 2007 study, Alegría et al. found that individuals who had been in the USA for under five years displayed significantly lower rates of utilization of mental health services than those who had been in the country

to more than 21 years. This is possibly due to the fact that as a Mexican immigrant becomes more established in the USA he or she may lose touch with the strong cultural values of early life and struggle with acculturation and forming an identity in the cultural context of the USA. Furthermore, as discussed in Pérez et al., 2008, as a Mexican immigrant learns to understand and speak more English and to perceive discriminatory remarks correctly, he or she may experience more mental health symptoms because of it. As one learns more about the systemic barriers and challenges to being an immigrant to this country he or she will likely feel more oppression and psychiatric problems associated with it. Taking this into account when working with mental health clients of this population can aid in establishing a greater rapport with these individuals, creating a safe environment, and ultimately improving the outcome of the treatment (Pérez et al., 2008). The MIOS Program used a Spanish language treatment plan in addition to the English language one that was filed in the client's record. The Spanish language treatment plan was shorter and more succinct, and allowed the client to conceptualize his or her goals in terms of which symptoms he or she would like to see change (MIOS Program, 2008). This is an example of small changes that may aid the mental health provider in creating this rapport with the client and providing a safe and comfortable environment for the individual.

Alegria et al. (2007) also reported that due to the fact that those who do not speak fluent English are less likely to find jobs that provide insurance coverage to employees, these individuals may be less likely to seek mental health services out of a lack of medical coverage. One of the reasons the MIOS program may have enrolled a greater number of immigrants who had not been in the country an extensive amount of time in

comparison with the Alegría et al. (2007) findings may have to do with the fact that the MIOS program was specifically targeted to provide services to those who are monolingual, Spanish-speaking, and un-insured. Alegría et al. found that un-insured individuals who were immigrants to the USA were not as likely as individuals who had insurance coverage to seek mental health services. This indicates a possibility that more funded programs offering services to this population may increase the rate of mental health service utilization. The data produced from the current study indicate that need is present for mental health services to this population, and the ability to serve the un-insured among this Latino population provides a unique and necessary service. Also, because the psychosocial needs of the MIOS sample were so great, it is possible the needs of the newer immigrant population differ from those of immigrants who have been in the USA for a longer period of time. Further research into these differences is recommended.

The psychiatrist through the MIOS Program provided a necessary and used service. The MIOS Program, while a part of Cascadia Behavioral Healthcare, provided a part-time, Spanish speaking psychiatrist to conduct psychiatric evaluations and prescribe medication to those clients in need. This was unique in Multnomah County, as these uninsured, Spanish-speaking individuals have very few low to no-cost resources to obtain psychiatric medication. Furthermore, because of the undocumented status of the MIOS Program clients, access is limited to an even greater extent. Mental health programs that offer services to this population should attempt to provide psychiatric care when possible, to offer the most comprehensive, wrap-around treatment possible.

While the majority of individuals in this sample had no prior or current suicidal risk noted, 26% reported past suicidal ideation and 14% reported suicidal ideation either in the past and during treatment or solely during treatment with the MIOS Program. This is another aspect of the necessity for mental health providers who are knowledgeable about crisis intervention with this population.

Forty-three percent of the sample had received prior mental health services either in their country of origin or with another organization in the USA. The remaining 57% had never received any type of therapy prior to calling the MIOS Program. Pérez and Fortuna (2005) posited in their study the importance of thoroughly explaining what therapy consists of, the concept of confidentiality, and laws specific to this country or the region in which the service is being provided, such as the Health Insurance Portability and Accountability Act (HIPAA). Discussing these with clients may require a longer amount of time and a greater amount of detail due to unfamiliarity with the mental health system in the USA and the language barrier. Finally, the most common referral source among this sample was in the “Other” category, which included referrals from medical providers and case managers in other organizations. The second most common referral source was that of friends and family members, followed by referrals from the Department of Human Services.

In summary, this study reinforces the findings of Pérez and Fortuna (2005), and provides information relevant to those who provide mental health services or administrators making decisions regarding services needed in an organization. There is a need for culturally competent and inexpensive (ideally, free) mental health services for the undocumented, uninsured, Spanish-speaking Latino population living in the USA.

When providing services to this population it is essential that the provider take into account the vast and complex array of cultural, economic, acculturative, and inter-related factors that these clients come in to treatment with and attempt to develop a treatment that will best serve the client's immediate needs as well as long-standing mental health symptoms.

As described above, culturally competent training is vital to providing mental health services to the Latino population in the USA. This training can include workshops, graduate school training focused on cultural competence, continued experience working with this population, and exposure to the countries of origin of clients. Treatment with this immigrant population should include a high amount of orientation to the concept of therapy, education about mental health issues, solution-focused treatment, coordination of resources, and access to psychiatric medication services when possible. Fluent Spanish speaking service providers will aid in providing the most comprehensive care and should be provided when possible.

Regarding recommendations for future research, because this study was conducted using adult demographics, a similar study should be conducted using data for the children who received treatment through the MIOS Program, to better understand the needs of Latino children growing up in the USA. Furthermore, as mentioned above, research regarding the possible differences in mental health service needs between recently immigrated Latinos and those who have been in the USA for a longer period of time is recommended, in order to provide recommendations for best care.

Because this study was conducted retroactively and the MIOS Program as operated with Cascadia Behavioral Healthcare is no longer in existence, this information

is intended to inform existing and new mental health service planning for this population. Programs such as MIOS are needed within the Portland, Oregon metropolitan area as the population of immigrants to the area continues to grow. Providing mental health services to this population will help promote a healthier outlook for these individuals and contribute to reduced rates of mental health problems. State and county funding will be important to pursue in the planning of new programs serving this population, and there is a continued need for culturally competent, bilingual providers as well. Finally, as Pérez and Fortuna (2005) reported, the providers should become involved in changing policy regarding these services and promoting preventative measures as well. It is important that as a part of being a culturally competent mental health provider one becomes involved in advocacy for this population in order to continue to improve the services available.

As described in Alegría et al. (2007), there is a need for more baseline data regarding Latinos in the USA in order to create goals, public policies, and systemic procedures that will improve the mental health of this population. Because of cultural differences in all ethnic populations, it is important to consider the background of individuals and attempt to provide services as culturally competent as possible in order to effect the most change. This study aimed to provide baseline data for the region of Portland, Oregon in an attempt to understand the needs of the Latino population in this area and provide an overview of services that will benefit the Latino people in the area.

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